THE HEALTH CARE TEAM IN THE MILE SQUARE AREA, CHICAGO*

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THE major problem facing medicine in the urban center today is the development of an organized approach to the delivery of medical care to large groups. Our challenge is to develop a system by which all members of the health profession can be brought together with the community to provide comprehensive health services for the population. The Mile Square Health Center is one such attempt. This center was established by a grant from the Office of Economic Opportunity to the Chicago Health Research Foundation of the Chicago Board of Health. The Research Foundation in turn signed a contract with the Presbyterian-St. Luke's Hospital, a voluntary teaching hospital affiliated with the University of Illinois, to develop a neighborhood health center in a poverty-stricken community on Chicago's west side. The neighborhood health center was established by the Section of Community Medicine of the Department of Medicine of the hospital. This enables us to bring the total resources of the hospital, its outpatient specialty services, and its inpatient facilities to bear upon the problem.

All members of the staff of the center are employees of the hospital and have all the rights and privileges that this entails. The physicians have the same status that attending men have and meet the same qualifications for appointment. Our goal is to give the patients the same entree to care through the center's physicians as they would have if this were a traditional group-practice unit organized by members of the attending staff.

The area being served is a square mile that contains a population of approximately 25,000 people, 8,600 of whom live in a large high-rise housing project; 560 live in a housing project for the elderly.

According to data for the 1960 census the median income was ap-

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proximately $3,400; the male unemployment rate was approximately 13.6 per cent. Slightly more than 40 per cent of the families in public housing and 25 per cent of the residents of other housing receive welfare assistance. Of the families in the public housing project 55 per cent are categorized as broken families (generally only a mother in the home). The usual mortality and morbidity statistics would indicate that this community is among those with the lowest health record; the infant mortality rate is 46 per 1,000.

How then does one organize health services to serve a population that has these characteristics? We have elected to organize our services around three echelons of care. The first is represented by the public health nurse and community health aide, who function primarily in the home. The second echelon is the center itself, where a core of internists, pediatricians, obstetrician-gynecologists, and psychiatrists and a supporting nursing and social work staff provide the usual office practice care. The center contains a laboratory, a pharmacy, and an x-ray department, as well as the usual administrative personnel. Our third echelon is the hospital itself, its specialty clinics, surgical facilities, and in-patient care.

What then is the function of the medical care team in such a setting? There is no single medical care team but rather multiple teams that interrelate at various levels. The first such team is the community and administrative staff of the center. This is undoubtedly the most difficult team to build and to develop into a smooth operating unit. The major members of this team are the project director, the administrator, and the community organizer from the center's staff, and the Neighborhood Advisory Council, selected by the community. The Neighborhood Advisory Council is selected by the members of the community through their block clubs, tenant councils, and the overall community organization which in our area is known as the Mile Square Federation. We successfully developed with the council a team approach to site selection, recruitment of personnel from within the community, and approval of personnel hired from outside the community. The project has developed training programs and job opportunities at the center for personnel from the community. Approximately 70 people from the community are now employed in positions such as community health aides, medical record clerks, clinic coordinators, secretaries, and technician trainees in laboratory, x ray, and phar-

macy as well as in positions as guards, drivers, etc. The council has played a key role in explaining the center to the community, in gaining its acceptance, and in developing criteria for eligibility for care. Major problems arise in relation to personnel policies within the center. The community at times may not understand the existing requirements for upward mobility of employees, and of the current salary structure. Such problems may lead to misunderstandings, but these problems must be worked through by cooperation and education on both sides. Once an understanding and cooperation are reached around these issues the team can move forward into the areas of the health program itself.

The next team is the administrative team within the center itself. This includes the project director, the medical director, the chief of the individual services such as medicine, pediatrics, nursing, social service, mental health, and the community organizer. All of these people must have clearly in mind the goals and the philosophy of the center and must interact daily if one is to develop a truly integrated program and not separate empires.

In addition to the daily interaction the chiefs meet weekly to review problems and programs. This group then serves as a policy-making group in developing new programs and defining areas of responsibility and developing cohesiveness in the operation of the programs.

Within departments there is yet another level of team interaction. Here the physician, the registered nurse, the licensed practical nurse, the aides, and the clerks must all function together. Agreement must be reached among all members as to the role of each, and there must be a free interchange and continual evaluation of roles. Our registered nurse in the clinic interviews patients after they have seen the physician and before they leave the clinic. She reviews medication, amplifies and explains any directions the physician has given, and carries out the education of the patient along specific areas as indicated by the patient or the physician. The patient's attitude toward health problems is also assessed, and the nurse may initiate referrals to other departments when she feels this is indicated. Our licensed practical nurses have been trained to do screening tests in vision, hearing, and glaucoma, and to take electrocardiograms. The aides who are members of the community assist in the taking of the history, relate closely with the patient, and often become aware of specific problems that the patient is reluctant to discuss with the professional staff. In this setting the physician

is in charge of the care and management of the patient, but each member of the team feels free to communicate to an appropriate member any problem of which they become aware.

Moreover in our program of preventive pediatric care our public health nurses are responsible for the well-baby visits after the initial evaluation by the pediatrician. The public health nurses have been given intensive in-service training by the chief of pediatrics to prepare them for their expanded role. Infants are seen initially by the pediatrician and at four-months intervals, while the nurse sees the infants for monthly visits during the intervening period. The nurse sees only well infants and those free from health deviations. She examines and evaluates the development of the infant, instructs the mother regarding child feeding and care, carries out the immunization program, and makes appropriate referral to the physician when she feels it is indicated. We are now in the process of developing nurse sessions for follow-up care for chronic illness, once a complete evaluation and determination of therapy has been made by the internist.

Our primary family health care team, however, centers around the public health nurse who acts as a family health counselor, and her trained community health aides. The community health aides are women who live in the area, primarily 30 to 40 years of age, who have been selected by a screening committee of the neighborhood advisory council. They receive a 12-week training program designed by the center's staff along with the American Red Cross and other community agencies. The program was designed to enable the aide to work as an assistant to the public health nurse and to free the nurse to work in depth with her families. The aides learn the rudiments of well-child care, of home nursing, and of working with the aged. After a first visit to a family the nurse and the aide jointly evaluate the health needs of the families. They will make general recommendations on health to the family and arrange for the necessary care in the center. The aide is responsible for much of the health education in the home, and does practically all of the child-care demonstrations, such as the making of formulas and infant baths. She also checks on missed appointments, assists with welfare problems and, when necessary, gives supportive care to some of the families with emotional problems. She sometimes accompanies patients to Presbyterian-St. Luke's Hospital or other agencies when necessary. The aide and the nurse review their cases

together daily and keep the physician informed of all pertinent data gained during visits to the home. During the first year of operation we have found that most of the work of the public health nurse and her aides centered around the very young and the very old. Care of the newborn infant, follow-up of children with mild illnesses seen at the center, and intensive work with families with severe deprivation has formed the major part of their program. Nursing for the chronically ill has also become a major part of our system for the delivery of care. Continual contact between the aides, the nurse, and the physician has enabled us in many circumstances to avoid hospitalization of the chronically ill which would have been necessary without these resources. The continued growth of the aides' ability during the course of a year in working closely with their nurses has been a gratifying experience. Not only have the aides been able to develop rapport with families whom the nurses could not have reached, but their knowledge of diseases has broadened. To hear the aides talk now about their diabetic patients, how they explain the reactions of insulin and the symptoms of diabetic coma is impressive. During the first year of operation each nurse had one aide working with her. We have just completed our second training program for an additional 18 community aides, and we expect to have in the field this year eight public health nurses, each assisted by three community health aides.

When one looks at the team of doctor, public health nurse, and aide one can see how the leadership of such a team changes with the circumstances and the needs. At one moment it may be the physician, at another moment or in another family it may be the nurse, and in yet a third it may be the aide who is in control of the situation for a particular period of time. In developing this particular team we have not only extended the services of the public health nurse by supplying her with the assistance of the aide but through in-service training we have also broadened the scope of the public health nurse to include a great deal of social work skills and responsibilities. We have tried to limit the number of individuals that must be specifically involved with each family. We have done this by utilizing our social worker, psychiatrist, community organizer, and nutritionist as consultants to the basic team when necessary. Direct service by the social worker and the psychiatrist are limited to those patients for whom the team deems it necessary. The length and depth of intervention by the social worker

or psychiatrist will vary, of course, according to the needs of the family as well as the skill of the nurse and her aide. Coordination of specialty consultations and work with other agencies within the community when indicated is also carried out by the nurse. During hospitalization the nurse, as well as the physician, visits the patient and handles many of the emotional and social needs of both the patient and the family.

The nurse thus contributes to maintaining continuity of care between the home, the Mile Square Center, and the hospital. She shares with hospital personnel appropriate information which facilitates the patient's care and assists in the solution of any problems which may interfere with the patient's medical management. In addition she takes responsibility on the maternity service for interpreting our infant-care program and the importance of the postpartum visit; she also encourages the patient to call for an appointment for her infant as soon as possible. She indicates to the mother that a home visit will be made within two weeks after discharge, and she leaves a card with the name of the nurse assigned to the family with instructions on how she may be reached. For the chronically ill she is also responsible for placement in the nursing home and for posthospital follow-up care.

Generally we believe that this approach to the integration of care has been successful, from the point of view of professional acceptance by both physicians and nurses, by acceptance on the part of the patient, and by our ability to utilize our medical manpower more effectively. We have been struck, however, by the number of disorders, both medical and social, as well as the number of families that can be classified as multiple-problem families. We are not yet sure of the amount of manpower needed to serve a community with this type of in-depth care.

We started giving service to patients in February of 1967 and, by March 28, 1968, approximately 9,800 individuals had been registered and seen at the center. This represents at least one individual from each of 4,000 families. We have thus reached more than half the population of the Mile Square area in this period of time. Home visits have been made to approximately 2,000 families, of which 20 per cent have been considered problem families by our community health nurse. We define problem families as those requiring intensive follow-up care in the home because of social, medical, emotional, or economic problems. These problems range from alcoholism to mental retardation to cultural

and social deprivation, drug addiction, and all of the conditions so eloquently described by our urban sociologists. To deal with these problems it has been necessary to supply intensive in-service training to all the personnel of the center by social scientists, physicians, psychiatrists, and community representatives. It has also required untold man-hours of effort by all members of the team. Let me give just one example.

The W. family was referred to us by a neighbor contacting a community health aide who was making a home visit in the same building. This family is composed of eight individuals representing three generations. There are the two parents, five children, and one grandchild. Seven of the eight members of the family are now registered at the center. Housing conditions are substandard and hazardous. The father is 73, has had a cerebrovascular accident with residual paralysis. His wife, 33, is being seen by our psychiatrist for chronic schizophrenia. There are three retarded children, two of whom had never been in school or received any type of training. Our efforts have been directed to the placing of the two retarded children in a special program developed by the park district in our area, and to work with the mother to improve her ability to function and to care for all the children. We feel that it was the intensive interest and ability to communicate with the family that was exhibited by the community health aide and the community mental health aide which made it possible for this family to accept the park-district facility and the medical care offered by the center. To measure success in such a family is difficult, but we have seen improvement and the aides are continuing their contacts. It took one year of continuous effort to accomplish this. We have many such families, and we are continually exploring new ways to deal with them effectively.

In essence the key to success of the neighborhood center program and the medical care team depends upon maintaining a multiple-discipline approach which is both flexible and innovative.